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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendants.

NO. 2:19-cv-00183-SAB

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND OPPOSITION TO DEFENDANTS' MOTION TO DISMISS OR FOR SUMMARY JUDGMENT

NOTED FOR: November 7, 2019
With Oral Argument at 10:00 AM
Location: Spokane, Washington

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I. INTRODUCTION

It is no coincidence that Defendants (hereinafter, HHS) voluntarily acquiesced in an injunction of the Final Rule Washington challenges in this action pending a final adjudication.[1] Under the guise of "clarifying" federal laws creating narrow refusal rights based on conscience, the Rule purports to create an absolute right for religious or moral objectors to refuse to provide healthcare information or services, radically expands the universe of who may assert a conscience objection, forces Washington's hospitals and medical centers to acquiesce in a religious employee's conscience objection even if the employee is unwilling to perform core functions, and makes Washington's continued receipt of billions of dollars of federal funding—including funding entirely unrelated to healthcare—conditioned on its and its subcontractors' adherence to the Rule.

The Rule is a continued chapter in HHS's efforts to stamp certain religious views onto how healthcare is provided in the United States. Indeed, the Rule was announced by President Trump at a Rose Garden Ceremony on the National Day

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[1] *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23170 (May 21, 2019) (to be codified at 45 C.F.R. Part 88) (the Rule); *see* 84 Fed. Reg. 26,580 (June 7, 2019) (corrected publication date); *see also* ECF No. 28 (establishing new effective date). Unless otherwise noted, all subsequent C.F.R. citations are to provisions of the Rule to be codified and effective November 22, 2019.

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of Prayer and was touted as establishing "***new protections of conscience rights*** for physicians, pharmacists, nurses, teachers, students, and faith-based charities."[2] While Washington has a carefully constructed tapestry of laws that balance providers' conscience rights with patients' rights to modern healthcare, HHS's Rule purports to preempt all these laws. As explained below, the Rule is unlawful for many reasons:

First, it exceeds HHS's statutory authority. The federal refusal statutes do not delegate to HHS authority to interpret them, nor do they authorize HHS's new, draconian enforcement powers.

Second, the Rule is contrary to law. HHS's definitions of statutory terms conflict with the underlying statutes, and the Rule itself purports to limit other federal laws safeguarding healthcare access.

Third, the Rule is arbitrary and capricious. HHS's primary justification for the Rule rests on a blatant fabrication of the administrative record, and HHS failed to meaningfully consider public comments pointing out the substantial harms the Rule will inflict.

Fourth, the Rule violates the Constitution. It is a paradigmatic example of executive branch overreach that invades Congress's power to attach conditions

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[2] https://www.whitehouse.gov/briefings-statements/remarks-president-trump-national-day-prayer-service/ (last visited Sept. 19, 2019) (emphasis added).

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on the use of federal funds, violates the Spending Clause proscription on gun-to-the-head coercion, and jettisons governmental neutrality between religion and nonreligion by requiring Washington healthcare institutions to conform their business practices to their employees' religious beliefs.

It is exceedingly rich for HHS to wrap itself in a flag of "tolerance" while running roughshod over Washington's guarantee that one person's religious objection will not deny another person's right to healthcare. The Rule violates the Administrative Procedure Act and the Constitution. Washington is entitled to summary judgment vacating the Rule.

II. ARGUMENT

A. Defendant's Motion to Dismiss Should Be Denied

HHS moves to dismiss Counts V and VII, arguing that these claims are not yet ripe for review because no enforcement action has been taken against Washington. Defs.' Mot. to Dismiss, or, in the Alternative, for Summ. J. (ECF No. 44) at 21–25. This argument misapplies the ripeness doctrine.

First, Washington's constitutional claims are ripe for review because the Rule requires Washington to "adjust [its] conduct immediately." *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871, 891 (1990). Washington has no choice but to immediately comply or risk losing billions of dollars in federal funds. *See* Compl. for Declaratory and Injunctive Relief (ECF No. 1) ¶¶ 6, 96, 108; 45 C.F.R. § 88.4. Further, Washington will have to spend millions of dollars to fund the significant

changes necessary to comply with and implement the Rule. *See* State of Washington's Mot. for Prelim. Inj. (ECF No. 8) at 52 (citing declarations); ECF No. 1 at ¶ 109. Because Washington will have to take immediate actions to comply with the Rule, its constitutional claims are ripe for adjudication.

Second, the "serious penalties attached to noncompliance" also support pre-enforcement review. *Abbott Labs. v. Gardner*, 387 U.S. 136, 152–54 (1967); *see also Thomas v. City of New York*, 143 F.3d 31, 36 (2d Cir. 1998). The Complaint alleges that the Rule will cause devastating injuries, including the threatened loss of billions of dollars, and the State's motion for preliminary injunction provides further detail of this harm. ECF No. 1 ¶¶ 42–49; ECF No. 8 at 13–14, 40–42, 44–45. In light of the substantial penalties Washington could face for noncompliance, immediate review is appropriate.

HHS's principal authority is unavailing. In *National Family Planning & Reproductive Health Association, Inc. v. Gonzalez*, 468 F.3d 826 (D.C. Cir. 2006), the plaintiff's claims were dismissed for lack of constitutional standing—an issue HHS does not raise here. In *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, *1 (N.D. Cal. Mar. 18, 2008), the court found a state's constitutional challenge to the Weldon Amendment not ripe. However, the court made clear that if the federal government challenged a state law "or refuse[d] to provide an answer, *thus leaving [the state] in a difficult position of putting at risk*

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billions of dollars in federal funds if it enforces its own statute, the case then would be ripe." *Id.* (emphasis added).

Finally, HHS itself identified an Office of Civil Rights (OCR) complaint involving Washington's Department of Corrections as a basis for this Rule. ECF No. 44 at 49; ECF No. 44-1. Its ripeness defense is thus particularly attenuated given its apparent open investigation of a Washington state agency.[3]

B. The Rule Violates the Administrative Procedure Act

Washington is entitled to summary judgment on its claims that the Rule violates the Administrative Procedure Act (APA) because "there is no genuine dispute as to any material fact and [Washington is] entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The APA holds that courts must "hold unlawful and set aside" agency action that is "in excess of statutory jurisdiction, authority, or limitations"; is "not in accordance with law"; or is "arbitrary, capricious [or] an abuse of discretion." 5 U.S.C. §§ 706(2)(A), (C). As explained below, Washington is entitled to summary judgment on *each* of these grounds.

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[3] The Court need not adjudicate HHS's unsupported and conclusory request to "dismiss Plaintiff's claims in their entirety" (ECF No. 44 at 19). *See* Fed. R. Civ. P. 7(b)(1)(B); LCivR 7(b)(1).

1. The Rule exceeds HHS's statutory authority in violation of the APA

The Rule violates the APA and must be held "unlawful and set aside" because it is in excess of HHS's statutory authority. 5 U.S.C. § 706(2); ECF No. 1, Count I and ¶¶ 112–13. "[A]n administrative agency's power to regulate in the public interest must always be grounded in a valid grant of authority from Congress." *Sierra Club v. Pruitt*, 293 F. Supp. 3d 1050, 1058 (N.D. Cal. 2018) (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 161 (2000)); *City of Arlington v. FCC*, 569 U.S. 290, 297–98 (2013). Some agencies are granted "broad power to enforce all provisions of [a] statute," while others, like HHS, have only "limited powers, to be exercised in specific ways." *Gonzalez v. Oregon*, 546 U.S. 243, 2580–59 (2006); *see, e.g.*, 42 U.S.C. § 18116(c) (limited authorization for HHS to "promulgate regulations to implement" Section 1557 of the ACA); *Pharm. Res. & Mfrs. of Am. v. HHS*, 43 F. Supp. 3d 28, 39 (D.D.C. 2014) (applying *Gonzalez* to reject HHS's attempt to string together various specific grants of authority to give it a broader rulemaking authority). Here, Congress never delegated to HHS the broad rulemaking, interpretive, and enforcement authority that HHS claims for itself.

a. HHS lacks authority to promulgate regulations implementing Church, Coats-Snowe, and Weldon

HHS's motion ignores the threshold issue of whether it has authority to interpret the Church, Coats-Snowe, and Weldon Amendments and instead launches directly into a defense of the reasonableness of its interpretations. ECF

No. 44 at 26–37. But the refusal statutes at issue do not grant it the authority to interpret these statutes. This absence of authority is fatal to the Rule.

"The starting point for this inquiry is, of course, the language of the delegation provision itself." *Gonzalez*, 546 U.S. at 258. The Church, Coats-Snowe, and Weldon Amendments do not explicitly delegate interpretive or enforcement authority to HHS, and HHS does not argue otherwise.

HHS tries to sidestep this flaw by insisting that the Rule merely clarifies the refusal statutes. 84 Fed. Reg. at 23182 ("The Department drafted the proposed rule to track the scope of each statute's covered activities as Congress drafted them"); *see also* ECF No. 44 at 2–3. In reality, however, the Rule creates rights and obligations far in excess of these refusal statutes. Indeed, it simultaneously imposes substantial new burdens on third parties while announcing draconian enforcement measures expressly intended to induce third parties to change their practices.

While HHS claims *Chevron*[4] deference to its interpretations, ECF No. 44 at 26, the basis of *Chevron* deference is that "Congress clearly delegated authority to the agency to make rules *carrying the force of law* and [] that the agency interpretation was promulgated in the exercise of that authority." *N. Cal. River*

[4] *Chevron, U.S.A., Inc. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984).

Watch v. Wilcox, 633 F.3d 766, 773 (9th Cir. 2011) (emphasis added).[5] Here, Congress made no delegation of authority. Moreover, HHS cannot maintain that the statutory interpretations in the Rule merely "track" obligations already imposed by the refusal statutes and then demand deference to such interpretations as having the force of law.

The Rule also is not entitled to *Chevron* deference because "[a] court does not defer to an agency's interpretation of a statute that it is not charged with administering." *Del. Riverkeeper Network v. Fed. Energy Regulatory Comm'n*, 857 F.3d 388, 396 (D.C. Cir. 2017). As noted above, nothing in Church, Coats-Snowe, or Weldon suggest that HHS is "charged with administering" them.

Weldon is an appropriations rider that issues instructions to various agencies. Courts owe no deference to agency interpretations of appropriations statutes or riders. *See U.S. Dep't of Navy v. Fed. Labor Relations Auth.*, 665 F.3d 1339, 1348 (D.C. Cir. 2012); *Ass'n of Civilian Technicians v. Fed. Labor Relations Auth.*, 370 F.3d 1214, 1221 (D.C. Cir. 2004). Similarly, HHS's interpretations of Church and Coats-Snowe receive no deference because they are statutes generally applicable to all federal agencies. *DLS Precision Fab LLC v. U.S. Immigration & Customs Enf't*, 867 F.3d 1079, 1087 (9th Cir. 2017).

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[5] Washington did not agree in its preliminary injunction motion that *Chevron* supplied the standard for assessing HHS's acting in excess of its statutory authority. *See* ECF No. 44 at 26; *compare* ECF No. 8 at 18.

Coats-Snowe is applicable generally to "[t]he Federal Government, and any State or local government that receives Federal financial assistance." 42 U.S.C. § 238n. Church is not applicable to any agency at all, but focuses on specific grants, contracts, loans, loan guaranties, and in some cases, individuals. 42 U.S.C. § 300a-7.

b. The Rule impermissibly expands HHS's enforcement authority

The Rule also exceeds HHS's statutory authority by creating draconian enforcement powers not authorized by Congress. 45 C.F.R. §§ 88.4–88.7. HHS can point to no delegation of authority in the refusal statutes for the broad new enforcement power it assumes. Instead, it implies in the "background" section of its brief that the Rule merely incorporates the generally applicable Uniform Administrative Requirements (UAR), 45 C.F.R. § 75.371, to justify its new enforcement regime. ECF No. 44 at 11–12.

But the Rule does not merely borrow already existing agency enforcement authority. HHS stated in the Rule that it had inadequate enforcement tools (84 Fed. Reg. at 23227–28), and its motion candidly admits that "the Rule undeniably revises HHS's approach to enforcing the Federal Conscience Statutes." ECF No. 44 at 47. The Rule cannot, therefore, be simply incorporating a presently existing generally applicable UAR, when HHS itself admits that it is *changing* its enforcement scheme.

The far broader enforcement power created by the Rule is evident from a review of the enforcement steps prescribed in the UAR. 45 C.F.R § 371. The UAR remedies focus on the specific "cost of the activity or action not in compliance" or the specific federal award involved. 45 C.F.R. § 75.371(b), (c). By contrast, the Rule confers the power to terminate, deny, and withhold *all* federal funding by HHS and, indeed, by other federal agencies as well. 45 C.F.R. § 88.7(i)(3). Further, the UAR provides that HHS will first consider placing additional conditions on funding recipient and pursue more aggressive remedies only after determining that those conditions cannot remedy the noncompliance. 45 C.F.R. § 75.371. In the Rule, however, HHS reserves the right to undertake involuntary enforcement *before* exhausting attempts to resolve the matter informally and warns of potential "funding claw backs," which are unavailable under the UAR. 45 C.F.R. § 88.7(i)(2); 84 Fed. Reg. at 23180. The UAR simply does not provide a basis for the vast enforcement authority HHS arrogates to itself in the Rule.

In addition, Church, Coats-Snowe, and Weldon are all silent on enforcement. Congress knows how to authorize enforcement schemes, and it chose not to do so here.[6] Accordingly, Congress's silence regarding enforcement

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[6] In Title VII of the Civil Rights Act, for instance, Congress expressly "authorized and directed" every agency administering federal grants, loans, or contracts to "effectuate the provisions of" Title VI "by issuing rules, regulations,

in the refusal statutes provides HHS with no basis to claim the broad power to terminate funding that it gives itself in the Rule.

2. The Rule is contrary to law in violation of the APA

a. The Rule's definitions of statutory terms exceed HHS's statutory authority and are not entitled to deference

Even assuming that HHS has authority to issue a rule on the underlying statutes at issue here, several definitions contained in the Rule impermissibly expand the statutes. Specifically, through its definitions of (i) "health care entity," (ii) "assist in the performance," (iii) "referral or refer for," and (iv) "discriminate or discrimination," HHS went far beyond the language of the statutes it purports to implement. By exceeding the bounds of the underlying statutes, HHS exceeds its statutory authority, making the Rule unlawful.

Defendants attempt to confuse the issue by arguing that their definitions are entitled to this Court's deference under *Chevron*. But such deference is unwarranted. First, as set forth above, *Chevron* is inapposite because Congress did not delegate authority to HHS to promulgate legislative rules concerning Church, Coats-Snowe, or Weldon. Second, even to the extent that *Chevron* is applicable, the Court need not apply it here because HHS has exceeded the scope

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or orders of general applicability." 42 U.S.C. § 2000d-1. As part of the delegation, however, Congress also provided procedural protections for funding recipients—protections that are noticeably absent from the Rule.

of any statutory authority by crafting definitions that are both contrary to the "unambiguously expressed intent of Congress" and unreasonable. *See Phoenix Mem'l Hosp. v. Sebelius*, 622 F.3d 1219, 1225 (9th Cir. 2010).

(1) "Health care entity"

Three statutes that the Rule implements (Coats-Snowe, Weldon, and Section 1553 of the ACA) expressly define the term "health care entity." By expanding these statutes to include entirely different individuals and entities not identified by Congress, HHS exceeds its authority. *See FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 541 (2009); *Gonzales*, 546 U.S. at 269–73; *City of Philadelphia v. Attorney Gen. of the U.S.*, 916 F.3d 276, 284–91 (3d Cir. 2019).

Coats-Snowe. The Coats-Snowe Amendment defines "health care entity" as "an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." 42 U.S.C. § 238n(c)(2). The Amendment, which is titled "Abortion-related discrimination in governmental activities regarding training and licensing *of physicians*," prohibits the federal government and those who receive federal funding from discriminating against "any health care entity . . . on the basis that" the entity "refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions," or "refuses to make arrangements" for such activities." 42 U.S.C. § 238n(a)(1)–(2). Thus Congress focused on the narrow

class of individuals to whom abortion training was relevant in its definition of "health care entity": physicians and those participating in training programs in the health profession. As Senator Coats, one of the Amendment's sponsors, made clear: the purpose of the legislation "was simply [to] address the question of training for induced abortion." 142 Cong. Rec. 5165 (daily ed. Mar. 19, 1996).

Ignoring the narrow class of individuals chosen by Congress to address a specific issue, the Rule's expansive regulatory definition now broadens Coats-Snowe's application far beyond the abortion-training context to now include "other health care professionals, including a pharmacist," "health care personnel," and "any other health care provider or health care facility." 84 Fed. Reg. at 23264.

Weldon. The Weldon Amendment provides that federal funds may not accrue "to a Federal agency or program, or to a State or local government," if the recipient "subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." Pub. L. No. 115-245, 132 Stat. 2981 § 507(d)(1) (2018) The Amendment then defines the term "health care entity" to include "an individual physician or health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization or plan." *Id.* § 507(d)(2).

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Despite the Amendment's limited definition, HHS once again expands the term beyond its statutory language to include entities that are entirely outside of the health profession—like health plan sponsors (typically employers), plan issuers (such as insurance companies), and third-party administrators (that perform claims processing and administrative tasks). *See* 84 Fed. Reg. at 23264.

HHS's Response. HHS argues that because Congress used the term "include" in its definition for Coats-Snowe and Weldon, what follows must be nonexhaustive. ECF No. 44 at 32–33. Not so. While the term " 'include' can signal that the list that follows is meant to be illustrative rather than exhaustive," courts examine what Congress included in the list to determine whether including the proposed definition would strain the meaning of the statute. *See Samantar v. Yousuf*, 560 U.S. 305, 317 (2010) (holding that the term "foreign state" does not encompass officials because the listed illustrative examples "are all entities" not people); *see also Wash. State Dep't of Soc. & Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 384 (2003) (a term must be "construed to embrace only objects similar in nature to those objects enumerated by the preceding" words). As set forth above, an examination of the statutory language and history reveals that Congress chose specific and distinct individuals and entities to fall within the scope of both the Coats-Snowe and the Weldon Amendments, based on their differing statutory objectives. HHS's attempt to use

"include" as a means to piggyback entire classes of entities distinct from those Congress intended to reach must fail. *Gonzales*, 546 U.S. at 269–73.

(2) "Assist in the performance"

HHS's attempt to broadly redefine "assist in the performance" fares no better. The Rule defines the term "assist in the performance" to mean "to take an action that has a specific, reasonable, and articulable connection to furthering a procedure or a part of a health service program or research activity," which "may include counseling, referral, training, . . . or otherwise make arrangements for the procedure . . . , depending on whether aid is provided by such actions." 45 C.F.R. § 88.2. While this definition claims to implement the Church Amendments, the context, structure, and legislative history make clear that the Rule has expanded the meaning of the term beyond what Congress provided. *See Fin. Planning Ass'n v. Sec. & Exch. Comm'n*, 482 F.3d 481, 487 (D.C. Cir. 2017).

The Church Amendments were passed in the 1970s after a Montana district court issued a temporary restraining order that compelled a Catholic hospital to allow its facilities to be used for a sterilization procedure. *See, e.g.*, *Taylor v. St. Vincent's Hosp.*, 523 F.2d 75, 76 (9th Cir. 1975); *Watkins v. Mercy Med. Ctr.*, 364 F. Supp. 799, 801 n.6 (D. Idaho 1973), *aff'd*, 520 F.2d 894 (9th Cir. 1975). The Church Amendments address "[s]terilization [and] abortion" and protect individuals and entities from being compelled "to perform or assist in the performance of any sterilization procedure or abortion." 42 U.S.C. § 300a-7(b).

As Senator Church, the Amendment's sponsor, explained: "The Amendment is meant to give protections to the physicians, to the nurses, to the hospitals themselves if they are religious affiliated institutions." 119 Cong. Rec. S9597 (daily ed. Mar. 27, 1973) (statement of Sen. Church). He further made clear, however, that "[t]here is no intention [] to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise by a legal operation." *Id.*

Nonetheless HHS now dramatically expands the statute's reach by defining "assist in the performance" in a manner directly contrary to the statute's intent as stated by Senator Church. In an attempt to evade this conclusion, HHS argues that "[t]he Court need only open the dictionary" to find that *Merriam-Webster* contains "the same common-sense definition as the Rule." ECF No. 44 at 27. But as explained above, in passing the Church Amendments, Congress was focused on the actual performance of an abortion or sterilization procedure—not "furthering" or providing "aid" regardless of whether and when a procedure is actually performed. If Congress intended to include all conduct that "further[s] a procedure," *see* 45 C.F.R. § 88.2, it would have said so. Instead, Congress used the term "performance," which limits the statutory scope to the medical execution of the procedure.

HHS's expansive definition is further contradicted by Congress's use of precise language elsewhere in the Amendments. For instance, while Congress

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used the term "counseling" in other Amendment provisions, "training" in Coats-Snowe, and "referrals" in Weldon, it did not include *any* of these terms in §§ 300a-7(b), or (c), or (d), which prohibit discrimination only on the basis of a refusal to "perform" or "assist in the performance" of an abortion or sterilization procedure. Because Congress knew how to draft legislation that would cover these activities when it wanted to, HHS has no authority to define a statutory term in a manner that Congress chose to forego.

Finally, the Rule extends the Church Amendments far beyond this tailored approach of Congress. While the statutory language of the Amendments is limited to individuals "performing" or "assisting" in the performance of the actual procedures, the Rule now extends coverage to *anyone* taking *any* action with an "articulable connection" to a procedure—including the scheduler who keeps the calendar. 84 Fed. Reg. at 23,186–87; ECF No. 44 at 28. Extending the Church Amendments far beyond their purpose, the Rule both exceeds HHS's statutory authority and is unreasonable in light of the plain language of the statute, its structure, and its statutory history. *See ACA Int'l v. FCC*, 885 F.3d 687, 692, 697–99 (D.C. Cir. 2018).

(3) "Referral or refer for"

The Rule's definition of "referral or refer for" also goes well beyond the plain language of the underlying statutes (Weldon and Coats-Snowe) and is inconsistent with congressional intent.

> The Rule defines "referral or refer for" as including the provision of:
>
> Information in oral, written, or electronic form (including names, addresses, phone numbers, email or web addresses, directions, instructions, descriptions, or other information resources), where the purpose or reasonably foreseeable outcome of provision of the information is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity or procedure.

84 Fed. Reg. at 23203. While HHS contends that "[t]he Rule's definition is consistent with Congress's intent," ECF No. 44 at 35, a review of the statutes implicated refutes this conclusion. Coats-Snowe, for instance, anchors "refer for" and "referral" to the training of induced abortions and applies only to an "individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions." 42 U.S.C. § 238n; *see also, e.g.*, 42 U.S.C. § 238n(a)(1) ("referrals for such training on such abortions"); 42 U.S.C. § 238n(a)(3) ("refer for training in the performance of induced abortions"). Weldon also uses the term "refer for" in the context of abortion, stating that none of the funds appropriated in the appropriations act may be made available to governmental entities that discriminate against any "institutional or individual health care entity" because the entity "does not provide, pay for, provide coverage of, or refer for abortions." Pub. L. No. 111-117, § 508(d)(1), 123 Stat. 3034 (2009).

The Rule's broad definition also conflicts with the common understanding of these terms in the medical regulatory context in which they are used. While

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HHS demands deference to its use of the Merriam-Webster dictionary's term "refer" in crafting its definition, ECF No. 44 at 35–36, it ignores the more specific meaning ascribed to the term in the medical context—for a provider to direct a patient to another provider for care. *See, e.g.*, Medicare.gov, Glossary-R, https://www.medicare.gov/glossary/r (last visited Sept. 19, 2019) (defining referral as "[a] written order from your primary care doctor for you to see a specialist or get certain medical services"); Ctrs. for Medicare & Medicaid Serv., Glossary, https://www.cms.gov/apps/glossary/default.asp?Letter=R&Language (last visited Sept. 19, 2019) ("Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services.").[7]

Third, HHS's decision to ignore the specific meaning of referral in the medical context and to broadly redefine it will lead to unreasonable results. For example, under the Rule, if a patient learns she is pregnant and asks a nurse or counselor whether abortion is legal in her state, the nurse or counselor could invoke the Rule and refuse to answer the question on the grounds that doing so

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[7] Even *Merriam-Webster* contains a "[m]edical [d]efinition of referral," which is "the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment." *See* https://www.merriam-webster.com/dictionary/referral (last visited Sept. 19, 2019).

constitutes a "referral" for abortion. But such behavior would violate principles of informed consent and run afoul of basic medical ethics. *See infra* 50–53. By crafting a definition of "referral or refer for" that is so broad as to permit any individual working in the health care setting to impede a patient's access to care and information, the Rule's definition is unreasonable and contrary to law.

(4) "Discriminate or discrimination"

The Rule's definition of "discriminate or discrimination" goes far beyond any reasonable understanding of those terms. Under the Rule, "[d]iscriminate or discrimination" means, *inter alia*, any negative change to an individual's "title," "position," or "status" as well as the denial of "any benefit[s] or privilege[s]" or the imposition of "any penalty" in employment. 45 C.F.R. § 88.2. This definition far exceeds the common legal definition of discrimination in federal case law—*i.e.*, the "failure to treat all persons equally when no reasonable distinction can be found between those favored and those not favored," *CSX Transp., Inc. v. Ala. Dep't of Revenue*, 562 U.S. 277, 286 (2011) (quoting Black's Law Dictionary 534 (9th ed. 2009))—and makes almost any adverse employment action towards objectors actionable regardless of whether the action might be legally justifiable.

Indeed, under the Rule, there is no apparent limit to what an employer must do to accommodate objecting employees unwilling to perform core job functions. For example:

- Employers are prohibited from asking before hiring whether the applicant has objections to "performing, referring for, participating

in, or assisting in the performance of" medical activities—even if those objected-to procedures are core functions of the job. 45 C.F.R. § 88.2 (5).

- Thereafter, an employer must have a "persuasive justification" to ask employees if they are willing to perform an essential job function to which they might object. *Id.*;
- Employers cannot create an accommodation that excludes a staff member from their "field[] of practice." 45 C.F.R. § 88.2 (6); and
- Whether discrimination has occurred depends on an employee's willingness to accept an accommodation, regardless of the reasonableness of such accommodation. 45 C.F.R. § 88.2(4).

HHS offers no convincing defense for the Rule's new sweeping definition of discrimination, which departs from the "widely understood" definition of discrimination contained in federal case law; nor does it address case law holding that, under the Weldon Amendment, it would be "anomalous" to equate "reassignment with discrimination." *Nat'l Family Planning & Reprod. Health Ass'n, Inc.*, 468 F.3d at 829–30.

Instead, HHS argues that because the definition states that it only includes actions "applicable to, and to the extent permitted by the applicable statute," it cannot exceed the statute. ECF No. 44 at 29. But despite this disclaimer, the definition goes on to define the term in unprecedented, unworkable ways that create serious Establishment Clause issues, *see infra* at 60–66. This, in turn, further underscores the unreasonableness of HHS's new statutory definition. *See,*

e.g., *Nat'l Mining Ass'n v. Kempthorne*, 512 F.3d 702, 711 (D.C. Cir. 2008) ("canon of constitutional avoidance trumps *Chevron* deference").

b. The Rule conflicts with existing healthcare laws in violation of the APA

The Rule also is contrary to law because it violates the statutes HHS purports to implement, including (i) EMTALA's mandate to provide emergency care, (ii) the ACA's non-interference mandate, (iii) the ACA's contraceptive coverage mandate, and (iv) the Title X non-directive mandate. *See Fed. Election Comm'n v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32 (1981) (regulations "inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement" are invalid).

(1) The Rule conflicts with EMTALA

Under EMTALA, a hospital cannot deny emergency medical care to patients with emergency medical conditions, including pregnant women where "the health of the woman or her unborn child" is "in serious jeopardy." 42 U.S.C. § 1395dd(e)(1). A hospital can only "discharge its duty under EMTALA" by conducting an appropriate screening designed to identify "acute" and "severe" symptoms. *Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1258 (9th Cir. 1995). Courts construing federal conscience protections have concluded that a balancing test in necessary in cases of emergency care. *See, e.g.*, *California*, 2008 WL 744840, at *4 (discussing the interplay between the Weldon Amendment and EMTALA and finding "no clear indication, either from the express language of

the Weldon Amendment or from a federal official or agency" that requiring emergency abortion services would ever violate Weldon); *see also* 151 Cong. Rec. H176-77 (daily ed. Jan. 25, 2005) (statements by Rep. Weldon explaining that "in situations where a mother's life is in danger a healthcare provider must act to protect the mother's life"). The Rule, however, fails to provide for any balancing.

The Rule simply states that "where EMTALA might apply in a particular case, the [HHS] would apply both EMTALA and the relevant law under this rule harmoniously to the extent possible." 84 Fed. Reg. at 23188. It contains no directive as to how or even whether emergency care is to be provided when it conflicts with the categorical refusal-of-care right that the Rule confers. Instead, the Rule provides that HHS will determine whether the hospital properly handled the objector's refusal of care, based on "the facts and circumstances." *Id.* at 23263. But the uncertainty of the Rule coupled with the possibility of draconian sanctions for noncompliance is utterly unworkable, particularly in the context of a medical emergency, as evidenced by the numerous comments submitted to HHS discussing examples of religiously-motivated refusals to provide emergency care in violation of EMTALA. *See infra* at 41–42, 44–46.

Rather than meaningfully addressing the conflict, HHS states that "[t]here is no conflict" and asserts that "the Court should not assume that some future, hypothetical conflict between EMTALA and the Rule will come to pass." ECF

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No. 44 at 44. But the record is clear that objections from just one member on a team or ambulance crew can radically disrupt the provision of patient care, particularly in life-threatening situations. *See infra* at 43–45; *see also, e.g.*, *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 222–23 (3d Cir. 2000) (discussing the claims of a nurse who refused to assist in emergency procedures involving pregnant patients and describing a situation in which the nurse refused to assist a patient with life-threatening placenta previa—"who was 'standing in a pool of blood' "—thereby delaying the patient's emergency procedure for thirty minutes. Accordingly, HHS's head-in-the-sand approach to emergency situations implicating EMTALA and its Rule should be rejected.

(2) The Rule conflicts with Section 1554 of the ACA

The Rule conflicts with Section 1554 of the ACA as well. Section 1554 generally prohibits HHS from issuing any regulation that interferes in the patient-provider relationship. Specifically, it prohibits HHS from promulgating any regulation that:

> (1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care; (2) impedes timely access to health care services, (3) interferes with communications regarding a full range of treatment options between the patient and the provider, (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions, (5) violates the principles of informed consent and the ethical standards of health care professions, or (6) limits the availability of health care treatment for the full duration of a patient's medical needs.

42 U.S.C. § 18114(1)–(6).

The Rule conflicts with Section 1554 in numerous ways.

- It authorizes anyone "assist[ing] in the performance of any lawful health service" to deny care, including "counseling" or "referral." 84 Fed. Reg. 23263, 23265.
- It allows doctors and their staff to withhold necessary information from patients that would allow them to make decisions for themselves, which is required for informed consent. *Id.*
- It undermines Washington's ability to provide for the delivery of critical health services and threatens delivery of patient care, particularly in emergency, rural, and end-of-life care settings. *See* ECF No. 8 at 26 (citing Moss Decl. (ECF No. 16) ¶ 8; Zahn Decl. (ECF No. 20) ¶ 8; Broom Decl. (ECF No. 9) ¶¶ 14, 17; Currey Decl. (ECF No. 11) ¶¶ 17–19; Taylor Decl. (ECF No. 19) ¶ 12).

These consequences violate all of the subsections of Section 1554.

HHS's arguments to the contrary cannot withstand scrutiny. HHS argues that Section 1554 involves only the "denial of information or services to patients," while the Rule denies nothing. ECF No. 44 at 39. But Section 1554 does not only bar regulations that "deny" information or care. It prohibits regulations that "create[] . . . barriers," "impede[] . . . access," "restrict," and "limit" healthcare and related information. Further, the Rule does authorize healthcare providers to deny information and services. For example, it allows anyone to refuse to take "any action that has a specific, reasonable, and articulable connection to furthering" an abortion, which includes making arrangements. 84 Fed. Reg. at 23263. And as HHS readily admits, the Rule allows

receptionists, EMTs, and even insurance adjusters to prevent patients from accessing care by withholding information. *See supra* at 17–20.

HHS also is wrong in arguing that the Rule "simply limits what the Government chooses to fund." ECF No. 44 at 40. Most of the refusal statutes are not limited to constraining what a recipient can do with government funds, but instead impose obligations that extend to activities that are not funded by the government. Further, HHS's claim that Section 1554 is inapplicable when HHS regulates government-funded programs cannot be squared with Section 1554's express prohibition on "any" regulation that invades the provider-patient relationship.

HHS next argues that Section 1554 applies only to regulations promulgated under the ACA. ECF No. 44 at 40. But this too ignores the express reach of the provision to "*any* regulation." Further, the immediately preceding section of the ACA reflects that Congress knew how to limit the applicability of a provision when it wanted to do so. *See* 42 U.S.C. § 18113 (providing that prohibition on discrimination related to assisted suicide applied to any health care provider receiving funding "under this Act" and any health plan created "under this Act").

The Court should reject HHS's position that Section 1554's proviso "notwithstanding any other provision in this Act" somehow limits Section 1554's applicability. Section 1554's "notwithstanding" clause "just shows which of two

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or more provisions prevails in the event of a conflict." *Nat'l Labor Relations Bd. v. SW Gen., Inc.*, 137 S. Ct. 929, 940 (2017). Section 1554 prevails over other provisions in the ACA; it is not limited to them. The "notwithstanding" clause "signals the drafter's intention that the provisions override conflicting provisions of any other section" of that act. *Cisneros v. Alpine Ridge Grp.*, 508 U.S. 10, 18 (1993).

HHS misrepresents Washington's position by characterizing it as contending that Section 1554 "gutted" the refusal statutes. ECF No. 44 at 40–41. But Section 1554's plain language applies to HHS regulations, not to statutes. Furthermore, as shown above, the Rule's expansive and unlawful interpretations violate Section 1554—not the underlying statutes themselves.

HHS's argument that Section 1554 "must give way" to the refusal statutes under the general versus specific canon of statutory construction also falls flat. ECF No. 44 at 42–43. This canon applies when there is a conflict between a general and specific statutory provision. But Section 1554 and the refusal statutes do not confict; instead, the conflict is between Section 1554 and the Rule, which misreads the refusal statutes.

Finally, the Court should reject HHS's invitation to ignore Section 1554 altogether because the statute's language is "open-ended." ECF No. 44 at 41–42. Section 1554's directives are sufficiently "clear and specific" to permit judicial review here, *see Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402,

411 (1971) (declining to apply exception). For the foregoing reasons, the Rule violates Section 1554 of the ACA and is unlawful.

(3) The Rule violates the ACA's contraceptive coverage requirement

The Rule also illegally conflicts with ACA's contraceptive coverage mandate. The ACA and the regulations implementing it require insurers to provide contraceptive coverage. 42 U.S.C. § 300gg-13(a)(4). Certain employers with religious beliefs that conflict with the use of contraceptives may seek an accommodation, but they must take certain steps that result in the health insurance carrier "provid[ing] contraceptive coverage for the organization's employees." *California v. Azar*, 911 F.3d 558, 567 (9th Cir. 2018). The accommodation recognizes the employers' "religious exercise while at the same time ensuring that women covered by [their] health plans 'receive full and equal health coverage, including contraceptive coverage.' " *Zubik v. Burwell*, 136 S. Ct. 1557, 1559 (2016) (per curiam).

The Rule, however, expands the Weldon Amendment's definition of the term "health care entity" to include a "plan sponsor," 45 C.F.R. § 88.2 (proposed), which effectively allows *any* employer who sponsors an insurance plan to object to providing coverage for contraception. Because the Rule's definition of "health care entity" also includes "health insurance issuers," an insurance plan can no longer be obligated to provide contraception coverage.

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Both of these provisions conflict with the ACA's contraceptive coverage requirement.

HHS attempts to sidestep this conflict by citing an ACA provision that disclaims that the statute has any effect on federal conscience protections. ECF No. 44 at 43. This overlooks that the conflict with the contraceptive coverage requirement is created by the Rule, not the refusal statutes.

(4) The Rule contravenes Title X

Since 1996, Congress has passed annual appropriations acts applicable to HHS requiring that all pregnancy counseling within a Title X program be nondirective. *See, e.g.*, Pub. L. No. 115-245, 132 Stat. 2981, 3070–71 (2018). Under this mandate, all recipients of Title X grant funds must ensure that counseling for pregnant patients offers "information on all options relating to her pregnancy, including abortion." *Id.* Congress did not create a conscience-based right for the applicants for Title X grants to refuse to comply with the non-directive mandate.

Yet by allowing anyone participating in the performance of the health services to refuse to provide information about abortion or other types of care that pregnant patients may need, the Rule permits Title X providers to violate the nondirective mandate. *See supra* at 17–20. This violates patients' rights under the statute to receive counseling that is nondirective and impartially discloses all treatment options.

HHS's response again conflates the Rule's unlawfully expansive refusal rights with the refusal statutes themselves. ECF No. 44 at 45–46. But the refusal statutes have coexisted with the nondirective mandate for years, and Washington does not suggest a conflict between them. Thus, there is no reason to conclude that the nondirective mandate "impliedly repealed" the refusal statutes.

3. The Rule is arbitrary and capricious in violation of the APA

In addition to violating multiple statutes, the Rule is arbitrary and capricious in numerous respects. Courts must set aside agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2). To survive judicial review, the agency action must be based on a "reasoned analysis" that indicates the agency "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co. (State Farm)*, 463 U.S. 29, 42–43 (1983) (citation and internal quotation marks omitted).

A rule is arbitrary and capricious where the agency "relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *State Farm*, 463 U.S. at 43. "[A]gency action is lawful only if it rests 'on a consideration of the relevant

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factors,' " *Michigan v. EPA*, 135 S. Ct. 2699, 2707 (2015) (quoting *State Farm*, 463 U.S. at 43), and the agency must consider "the advantages *and* the disadvantages" of the proposal before taking action, *State Farm*, 463 U.S. at 43.

When an agency reverses position, it must "supply a reasoned analysis for the change." *Id.* at 42. If it departs from a well-established prior policy that "engendered serious reliance interests"—as HHS has done here—the agency must provide a more "detailed justification" for its actions. *FCC*, 556 U.S. at 515; *see also Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016). As explained below, HHS's Rule is arbitrary and capricious for several reasons (any one of which renders the Rule invalid): (i) HHS misrepresented the administrative record for its primary justification for the Rule; (ii) has no evidentiary basis for its other justifications for the Rule; and (iii) failed to consider or meaningfully address evidence of the severe harms the Rule will inflict—including on vulnerable populations and in emergency situations.

a. HHS flatly misrepresented the administrative record for its primary justification for the Rule

First, the Rule is arbitrary and capricious because it is based significantly on purported facts that are contradicted by the administrative record. To survive review under *State Farm*, "the facts on which the agency purports to have relied [must] have some basis in the record . . . ." *Fulbright v. McHugh*, 67 F.Supp.3d 81, 89 (D.D.C. 2014), *aff'd sub nom. Fulbright v. Murphy*, 650 F. App'x 3 (D.C. Cir. 2016). Courts will not "defer to an agency's unsupported reasoning which is

directly contradicted by the record." *Georgia River Network v. U.S. Army Corps of Eng'rs*, 517 F. App'x 699, 701 (11th Cir. 2013); *accord Defs. of Wildlife v. Babbitt*, 958 F. Supp. 670, 681 (D.D.C. 1997) (reversing agency action where agency "made several critical factual findings that are directly contradicted by the undisputed facts in the Administrative Record"); *Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1220 (9th Cir. 2008).

Here, HHS claimed that the Rule was necessary because of a surge in complaints for violations of the refusal statutes since President Trump took office. Indeed, HHS listed this as the very first justification in the Rule section entitled "Overview of Reasons for the Rule." 84 Fed. Reg. at 23175:

> Since November 2016, *there has been a* ***significant increase*** *in complaints filed with OCR alleging violations of the laws that were the subject of the 2011 Rule*, compared to the time period between the 2009 proposal to repeal the 2008 Rule and November 2016. ***The increase*** *underscores the need for the Department to have the proper enforcement tools* available to appropriately enforce all Federal conscience and anti-discrimination laws.

84 Fed. Reg. at 23175 (emphases added); *see also* 83 Fed. Reg. 3880, 3887 (May 21, 2019); 84 Fed. Reg. at 23183, 23229.

Now that Washington has the administrative record it has analyzed those complaints and determined the vast majority have nothing to do with the Rule.[8]

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[8] To complete this review, counsel for Washington coordinated with lead counsel in a similar action challenging the Rule pending in the Southern District

Of the 336 complaints to the HHS Office of Civil Rights (OCR) in the administrative record, a ***mere 6%*** allege conduct even arguably implicated by the relevant refusal statutes or the Rule. Molinas Decl. ¶¶ 14, 17.[9]

It is worth recognizing that this number of complaints (336) is miniscule—barely 1%—compared to the total number of complaints OCR receives annually (more than 30,000). Even more damning, of the 336 unique post-election complaints, 94% of them (315 complaints) do not allege violations of the refusal statutes at all. Molinas Decl. ¶ 14. Instead, careful analysis of the administrative record shows that approximately 80% of the complaints in the record (266 complaints) address the efficacy of vaccinations, which HHS admits is beyond the scope of the Rule. Molinas Decl. ¶ 15; *see also* 84 Fed. Reg. at 23183 ("the creation of a new substantive conscience protection is outside the scope of this rulemaking"). And an additional 49 non-vaccination related complaints do not allege violations of the refusal statutes for other reasons. Molinas Decl. ¶ 16. In short, a review of the administrative record reveals that ***only 21 of the 336*** unique

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of New York (Case No. 19-civ-5435). The Declaration of Alexa Kolbi-Molinas (Molinas Decl.), provides a detailed discussion of how the administrative record was reviewed and analyzed.

[9] There are 336 unique complaints in the record that postdate the November 2016 election, not, as HHS incorrectly claims in the Rule, "343 complaints alleging conscience violations" in FY 2018 alone. 84 Fed. Reg. at 23229.

complaints in the record—a mere 6%—even allege conduct that could potentially be covered by the refusal statutes. Molinas Decl. ¶ 16.

Accordingly, the administrative record provides no support for HHS's claims that "allegations and evidence of discrimination and coercion have existed since the 2008 Rule and increased over time," and it affirmatively rebuts HHS's claim of a "significant increase" in complaints since November 2016. 84 Fed. Reg. at 23175. In addition, HHS's assertion that 343 complaints in FY 2018 allege violations of the refusal laws is patently false as nearly 80% of them address matters outside the scope of the rule (e.g., vaccination complaints). *Id*. at 23229. Because "[a]gency action based on a factual premise that is flatly contradicted by the agency's own record does not constitute reasoned administrative decisionmaking," HHS's Rule "cannot survive review under the arbitrary and capricious standard." *City of Kansas City, Mo. v. Dep't of Hous. & Urban Dev.*, 923 F.2d 188, 194 (D.C. Cir. 1991); *see also, e.g.*, *Nat. Res. Def. Council v. Rauch*, 244 F. Supp. 3d 66, 96 (D.D.C. 2017) ("Suffice it to say, it is arbitrary and capricious for an agency to base its decision on a factual premise that the record plainly showed to be wrong.").

b. HHS's other justifications for the Rule likewise cannot withstand scrutiny

(1) The administrative record refutes HHS's claim that it needs more enforcement tools

The other reasons HHS gives for the Rule are equally devoid of merit. HHS

cites "inadequate enforcement tools to address unlawful discrimination and coercion," 84 Fed. Reg. at 23228, but the complaints it cites are overwhelmingly outside the scope of the Rule, and it produces no evidence that it lacks enforcement authority for the few complaints that would fall within the boundaries of the Rule. It is not rational to promulgate new enforcement tools to address complaints that cannot be redressed by those tools.

Furthermore, there is no indication that HHS investigated the vast majority of the complaints in the administrative record, again belying its need for new enforcement tools. Of the 336 complaints in the administrative record, Washington is only aware of 14 that were resolved by HHS. Molinas Decl. ¶ 18 and Ex. H. And only one of those complaints was filed in fiscal year 2018. Molinas Decl. ¶ 18. Nor is Washington aware of any other evidence in the record regarding whether HHS resolved or even attempted to investigate any of the other complaints filed in fiscal year 2018. Molinas Decl. ¶ 18. And in any event, the administrative record further reveals that in the few instances where OCR did investigate complaints, they were able to resolve them with their current enforcement tools. *See, e.g.*, Bays Decl., Ex. 1 (complaint closed for failure to state a claim of discrimination); Bays Decl., Ex. 2 (complaint withdrawn after grantee took actions to come into compliance).

Accordingly, HHS's claim of inadequate enforcement tools falls flat and this Court need not defer to its unsupported pronouncements.

(2) HHS's evidence of an "environment of discrimination and coercion" is exaggerated

Next HHS identifies two sources of "significant evidence of an environment of discrimination and coercion" justifying the Rule. 84 Fed. Reg. at 23175. The first, however, is a sentence plucked from a "perspective" column by a single physician in the *New England Journal of Medicine*—essentially a private opinion expressed in a guest op ed. *Id.* HHS does not explain how a single private physician's opinion can create an environment of discrimination and coercion.

HHS's second source is a 2009 survey in which "91% of the respondents reported that 'they would rather stop practicing medicine altogether than be forced to violate [their] conscience.' " *Id*. HHS cites this survey repeatedly, and no other survey is cited more in the Rule or given more weight. *See, e.g.*, 84 Fed. Reg. at 23181, 23228, 23246 n.309, 23247 nn.316–18, 23250 n.340, 23253 nn.347 & 349. While HHS now attempts to distance itself from the 2009 survey (ECF No. 44 at 51–52), a review of the Rule reveals its import in the agency's decision-making.

This survey, however, cannot bear the weight that HHS places up on it. The 2009 survey is actually a decade-old polling conducted by Kellyanne Conway's company on behalf of the Christian Medical and Dental Association. Bays Decl., Ex. 3. Ms. Conway's firm conducted two telephone surveys of American adults, one in 2009 and another in 2011, and an online survey of "self-select[ed]" members of faith-based medical organizations, including the

Christian Medical Association. Bays Decl., Exs. 3–4. But even Ms. Conway herself acknowledged that this poll was "intended to demonstrate the views and opinions [solely] of members surveyed" and "*was not intended to be representative* of the entire medical profession or [even] the entire membership rosters of these organizations." Bays Decl., Ex. 3 at AR 548710 (emphasis added). Moreover, even if this survey was relevant outside its narrow sample, which it is not, polling from a decade earlier is not informative of conditions today, when "one in six patients receiving medical attention every day" are seen at Catholic-affiliated institutions. E. Barczak, *Ethical Implications of the Conscience Clause on Access to Postpartum Tubal Ligations*, 70 Hastings L.J. 1613, 1621 (2019).[10]

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[10] The Rule also states that "[c]omments received during the rulemaking that led to the 2011 Rule were consistent with [Ms. Conway's] survey" and that "[t]ens of thousands of comments to the 2009 proposed rule expressed concern that, without robust enforcement of Federal conscience and anti-discrimination laws, individuals with conscientious objections simply would not enter the health care field, or would leave the professions, and hospitals would shut down . . . ." 84 Fed. Reg. at 23175–76. But tens of thousands of these comments are simply identical form letters. *See, e.g.*, 84 Fed. Reg. at 23176 n.20 (citing various form letters with, alternatively, 1,916 copies, 9,532 copies, 3,272 copies, 3,516 copies,

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Thus, HHS's claims of an environment of discrimination lacks a credible evidentiary basis.

(3) Even the administrative record evidence cited in HHS's brief does not support the Rule

After conceding that the Rule's citation to a supposed record of hundreds of conscience-based complaints is false, *see* ECF No. 44 at 49 (acknowledging that "a large subset" of the complaints it cited "complain of conduct that is outside the scope of the Federal Conscience Statutes and the Rule"), HHS's motion points to just ***three*** complaints in the entire administrative record that purportedly "implicate the relevant statutes." ECF No. 44 at 49 (citing ECF Nos. 44-1, 44-2, 44-3). But an analysis of this scant list of complaints undermines rather than supports the Rule.

The first complaint HHS cites (ECF No. 44-1) is an OCR complaint by an employee of the Washington State Department of Corrections who alleges discrimination based on his refusal to continue hormone therapy for an incarcerated transgender person. ECF No. 44 at 49; Bays Decl., Ex. 5. HHS fails, however, to explain how the Rule would apply to this complaint. Nor does HHS identify the funding stream by which it pays for this or any other prisoner's care. *See* Curry Decl. (ECF No. 11) ¶ 6. Therefore, the enforcement tools the Rule

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and 4,842 copies); n.21 (same; with 3,196 copies, 1,685 copies, and 2,002 copies); n.22 (same; with 8,472 copies); n.25.

creates do not appear to apply to this individual's allegations.

The second complaint HHS cites (ECF No. 44-2) is an OCR Complaint from the American Association of ProLife Ob-Gyn, which attaches a 2018 letter from the group complaining about a November 2007 ethics statement by the American Academy of Obstetricians and Gynecologists (ACOG) dealing with elective abortions. The refusal statutes, however, generally prohibit discrimination by governmental or government-funded entities—not private professional organizations like ACOG. *See* ECF No. 1 ¶¶ 30–31, 33–34. Since ACOG is not subject to the refusal statutes, the enforcement tools created by the Rule do not apply to this complaint either.

This leaves a single complaint (ECF No. 44-3) identified in HHS's brief that even arguably states a violation of the refusal statutes. But this remaining complaint fails to support HHS's express justification for the Rule: "a significant increase in complaints filed with OCR *alleging violations of the laws that were the subject of the 2011 Rule*." 84 Fed. Reg. at 23175 (emphasis added). Nor does the face of the complaint lend any support to HHS's second justification that it has inadequate enforcement tools at its disposal to address the issues it presents. 84 Fed. Reg. at 23228. In fact, nothing in the record reflects HHS's assessment or investigation of this complaint.

* * *

In sum, a close review of the administrative record reveals that HHS's

claim that there was "a significant increase in complaints with OCR alleging violations of the [conscience] laws" is patently false. Instead, HHS fabricated a "significant increase" in order to overturn prior agency policy and to justify bolstering its "enforcement tools." But an administration change does not authorize HHS's unreasoned and unsupported rulemaking. *See, e.g.*, *State v. U.S. Bureau of Land Mgmt.*, 277 F. Supp. 3d 1106, 1123 (N.D. Cal. 2017). Because HHS "based its decision on a factual premise that the record plainly showed to be wrong," the Rule is arbitrary and capricious and should be vacated. *Nat. Res. Def. Council*, 244 F. Supp. 3d at 96.

c. HHS failed to consider or meaningfully address evidence of severe harms the Rule will inflict

Under the APA, a regulation is arbitrary and capricious if the agency, among other things, "entirely failed to consider an important aspect of the problem." *State Farm*, 463 U.S. at 43. As set forth below, there can be no doubt that HHS failed to consider many devastating effects associated with the Rule, including: (i) significant disruption in the provision of medical services; (ii) interference with EMTALA; (iii) harms to public health and vulnerable populations; (iv) the contravention of basic medical ethics; and (v) departure from the Title VII framework. For these reasons as well, the Rule is arbitrary and capricious.

(1) HHS failed to consider evidence showing the Rule will undermine the provision of medical services

HHS received comments from a wide range of healthcare provider systems and national organizations, collectively representing millions of healthcare workers and recipients, discussing the catastrophic effects the Rule will have on the provision of medical services. These impacts stem from the Rule's new definitions of "discrimination," "referral," "healthcare entity," and "assist in the performance," which, as discussed above, dramatically expand the number of prospective objectors while at the same time drastically curtailing employers' ability to learn about and accommodate religious objections, thereby significantly limiting providers' ability to provide undisrupted medical services to patients—particularly in emergency situations. Some of the comments submitted to HHS on this issue warned that:

- "[A] provider with religious or moral objections to blood transfusions [could] refuse to offer that treatment to a patient with a life-threatening condition and fail to refer the patient to a provider who does not have an objection." Bays Decl., Ex. 6 at AR 139641 (comment by Kaiser Permanente).

- Employees of commercial health insurers responding to customers' inquiries may refuse to give "information as to coverage of their insurance benefits or coverage for the actual services, thus potentially impacting members' health." Bays Decl., Ex. 7 at AR 140273 (comment by Blue Cross Blue Shield Association).

- "[A] receptionist can refuse to schedule a patient's pregnancy termination or appointment for contraception consultation." Bays Decl., Ex. 8 at AR 56918 (comment by American Nurses Association).

- "[A]n ambulance driver may refuse to drive a woman experiencing severe pregnancy complications to a hospital, citing a religious objection to participating in procedures that may end the pregnancy." Bays Decl., Ex. 9 at AR 160640 (comment by Center for American Progress).

- "[A] pharmacist could refuse to fill a prescription for birth control or antidepressants, a woman could be denied life-saving treatment for cancer, or a transgender patient could be denied hormone therapy." Bays Decl., Ex. 10 at AR 160752 (comment by Planned Parenthood Federation of America).

- "[A] case manager [might] refuse to set up a medical appointment for a person with a disability to see a gynecologist if contraceptives might be discussed, [a] personal care services provider [might] refuse to assist a person with a disability in performing parenting tasks because the person was married to someone of the same gender, [a] mental health service provider [might] refuse to provide needed treatment to an individual based on the fact that the individual was transgender, and [a] sign language interpreter [might] refuse to help a person communicate with a doctor about sexual health." Bays Decl., Ex. 11 at AR 160776 (comment by Consortium for Citizens with Disabilities).

As the American Medical Association (AMA) aptly warned, under the Rule, "*any* entity in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—[may] use their personal beliefs to determine a patient's access to care." Bays Decl., Ex. 12 at AR 139590 (emphasis added).

Further, without any requirement that employees either provide their employers with advance notice of their objections or accept offers of reasonable accommodations, commenters warned that the Rule will make it impossible for service providers to anticipate the myriad possible objections that might disrupt their operations and undermine patient care. *See, e.g.*, Bays Decl., Ex. 13 at AR

161483 (comment by Lambda Legal) (discussing the burden of "hir[ing] duplicate staff . . . to ensure patient needs are met by employees willing to perform basic job functions").

Even though it received an alarming number of comments from professional medical associations and national organizations that raised concerns about the Rule's impact on patient care, HHS fundamentally failed to address these comments. This glaring deficiency renders its decision arbitrary and capricious. *See, e.g.*, *SecurityPoint Holdings, Inc. v. Transp. Sec. Admin.*, 769 F.3d 1184, 1188 (D.C. Cir. 2014) (invalidating agency action as arbitrary and capricious where agency failed to consider evidence it received of potentially significant harm to a regulated industry).

(2) HHS ignored the devastating consequences the Rule will have on emergency medical services

In addition to the significant harms the Rule will inflict on the provision of medical services generally, commenters also offered evidence on the devastating effects the Rule will have on emergency medicine specifically. Because HHS failed to reconcile the Rule with EMTALA—notwithstanding the numerous comments discussing the life-or-death impact the Rule could have in emergency medical situations—the Rule is arbitrary and capricious and should be set aside.

EMTALA requires providers to treat patients in certain emergency situations (including pregnant women). *See supra* at 22–24. But the Rule is completely silent as to what responsibilities, if any, objectors might have in such

circumstances. Numerous commenters highlighted this troubling omission as fundamentally inconsistent with the practice of emergency medicine, which often depends on small crews working together to save lives quickly, in unison, and with little margin for error. For example, the American College of Emergency Physicians urged HHS to withdraw the Rule, explaining that:

> emergency departments operate on tight budgets and do not have the staffing capacity to be able to have additional personnel on hand 24 hours a day, 7 days a week to respond to different types of emergency situations that might arise involving patients with different backgrounds, sexual orientations, gender identities, or religious or cultural beliefs.

Bays Decl., Ex. 14 at AR 147982 ("By not addressing the rights and needs of patients undergoing an emergency [and] the legal obligations of emergency physicians . . . this rule has the potential of undermining the critical role that emergency departments play across the country."). The AMA similarly warned that the Rule "could result in danger to patients' health, particularly in emergencies involving miscarriage management or abortion, or for transgender patients recovering from transition surgery who might have complications . . . ." Bays Decl., Ex. 12 at AR 139592.

In adopting the Rule, however, HHS largely brushed these concerns aside despite acknowledging that it received "many comments" on the issue. *See* 84 Fed. Reg. at 23182–23. HHS's response was that the Rule "does not go into detail about how its provisions may or not interact with other statutes in all scenarios" but that "[w]ith respect to EMTALA, the Department *generally agrees* with the

explanation in the preamble to the 2008 Rule that the requirement under EMTALA that certain hospitals treat and stabilize patients who present in an emergency does not conflict with Federal conscience antidiscrimination statutes laws." *Id.* at 23183 (emphasis added). But this is simply insufficient to meet the APA's requirement of reasoned decisionmaking. As are HHS's generalized conclusions, which fail to respond to the significant concerns raised by commenters. *See AEP Texas N. Co. v. Surface Transp. Bd.*, 609 F.3d 432, 441 (D.C. Cir. 2010) ("By relying only on generalized conclusions . . . the [agency] 'entirely failed to consider an important aspect of the problem,' making its [conclusion] arbitrary and capricious" (*citing State Farm*, 463 U.S. at 43)); *see also PPL Wallingford Energy LLC v. Fed. Energy Regulatory Comm'n*, 419 F.3d 1194, 1198 (D.C. Cir. 2005) ("An agency's 'failure to respond meaningfully' to objections raised by a party renders its decision arbitrary and capricious.").

While HHS now attempts to downplay any potential harm to emergency services by stating incredulously that it is "not aware of any instance where a facility required to provide emergency care under EMTALA was unable to do so because its entire staff objected to the service on religious or moral grounds," ECF No. 44 at 44, this contention is directly contradicted by evidence submitted during the public comment period. *See, e.g.*, Bays Decl., Ex. 15 at AR 147747 (comment by ACLU) (describing an incident in which a woman was turned away three times from a hospital where she sought urgent care, despite that her life

"could be in jeopardy if she did not obtain emergency abortion care for her miscarriage").

In sum, HHS's cursory response to these life-or-death concerns falls far short of what is necessary to justify a sweeping overhaul of medical services, particularly where emergency service providers have made clear that the Rule will endanger patients' lives. For this reason too, the Rule is arbitrary and capricious. *See Perez v. Mortgage Bankers Ass'n*, 135 S. Ct. 1199, 1209 (2015) (agencies must provide "substantial justification" when departing from prior policies with "serious reliance interests that must be taken into account").

(3) The Department disregarded evidence of substantial harms to vulnerable populations

The Rule is arbitrary and capricious because HHS disregarded the comments and evidence showing that the Rule would severely and disproportionately harm certain vulnerable populations, including, *inter alia*: women; lesbian, gay, bisexual, and transgender people (LGBT); individuals with disabilities; and people living in rural areas.

For example, many commenters noted the Rule would worsen health outcomes and increase discrimination against women seeking treatment for a host of conditions, including pregnancy and family planning. *See, e.g.*, Bays Decl., Ex. 16 at AR 149142–43 (comment by National Women's Law Center) (cautioning that the Rule "would further entrench discrimination against women[,] who already face high rates of discrimination in health care," including

that they "are more likely not to receive routine and preventive care than men, [and] when women are able to see a provider, women's pain is routinely undertreated and often dismissed"); Bays Decl., Ex. 17 (comment by National Health Law Program) (explaining that when women in rural communities are refused life-preserving medical care, they often "have nowhere else to go").

Commenters also highlighted the serious obstacles to care the Rule would create for (i) LGBT patients, *see, e.g.*, Bays Decl., Ex. 17 at AR 139863 (comment by National Health Law Program) (cautioning that the Rule will "compound the barriers that LGBTQ individuals face, particularly the effects of ongoing and pervasive discrimination by potentially allowing providers to refuse to provide service and information vital to LGBTQ health"); (ii) persons with disabilities, *see, e.g.*, Bays Decl., Ex. 11 at AR 160776 (comment by Consortium for Citizens with Disabilities) ("Discrimination in the provision of health care based on religious grounds presents particular concerns for people with disabilities, because many people with disabilities rely heavily on religiously affiliated service providers for daily supports [and] those service providers—particularly residential service providers—are frequently responsible for assisting with many aspects of a person's life."); and (iii) persons living in rural communities, *see, e.g.*, Bays Decl., Ex. 12 at AR 139863 (comment by AMA) ("In rural areas, there may simply be no other sources of health and life preserving medical care."); Bays Decl., Ex. 18 at AR 67174 (comment by Washington State

Department of Health) ("If the only provider in an area does not administer vaccines because it is against his or her personal religious beliefs[,] entire communities could be left vulnerable to devastating infectious diseases."). As the National Women's Law Center further explained to HHS in its comment:

> This discrimination in health care against women, LGBTQ persons, and those facing multiple and intersecting forms of discrimination is exacerbated by providers invoking personal beliefs to deny access to health insurance and an increasingly broad range of health care services, including birth control, sterilization, certain infertility treatments, abortion, transition-related care, and end-of-life care.

Bays Decl., Ex. 16 at AR 149152.

While conceding that patients in these vulnerable populations likely do "face health care disparities of various forms," HHS nevertheless dismissed the majority of these comments as providing only anecdotal evidence of discrimination unsuitable for extrapolation or reliable analysis. 84 Fed. Reg. at 23251–52. For example, HHS disregarded many "anecdotal accounts of discrimination from LGBT" people, as the accounts "offer no suitable data for estimating the impact of this rule." *See id.*; *see also* ECF No. 44 at 54 (explaining that a comment detailing incidents of discrimination against LGBT patients "contained only anecdotal evidence—thus making it unfit for extrapolation").

But HHS's dismissal of this pertinent evidence is fatally inconsistent, as the agency relied extensively on anecdotal evidence elsewhere to support the Rule. *See, e.g.*, 84 Fed. Reg. 23228 (discussing "[c]omments received in support

of the proposed rule" including "anecdotes of bias and animus in the health care sector against individuals with religious beliefs or moral convictions"); *id.* at 23247 (concluding the Rule is likely to increase entry into the health profession based on "significant anecdotal evidence" HHS received); *id.* (noting favorably that "several commenters agreed anecdotally" with HHS's conclusions); *see also id.* at 23175 (repeatedly citing as support for the Rule a decade-old Kellyanne Conway survey analyzing exclusively anecdotal responses from self-selecting survey participants). This "internally inconsistent" treatment of anecdotal evidence—relying upon it when it supports the Rule, but dismissing it when it does not—renders the rulemaking process arbitrary and capricious. *See Nat. Res. Def. Council v. U.S. Nuclear Regulatory Comm'n*, 879 F.3d 1202, 1214 (D.C. Cir. 2018) ("Of course, it would be arbitrary and capricious for the agency's decision making to be 'internally inconsistent.' "); *see also Water Quality Ins. Syndicate v. United States*, 225 F. Supp. 3d 41, 69 (D.D.C. 2016) (reversing agency decision that "cherry-pick[ed] evidence").

Nor can HHS dismiss these concerns as merely focusing on pre-existing discrimination and health inequities rather than effects likely to result from the Rule's implementation. *See* ECF No. 44 at 53–54 (arguing that comments discussing discrimination against vulnerable populations "did not attempt to answer the question of how the Rule itself would affect access to health care"). As an initial matter, HHS's argument is unsupported by the record. *See, e.g.*, Bays

Decl., Ex. 13 (comment by Lambda Legal) (providing objective statistics and qualitative evidence of widespread discrimination against LGBT patients, and projecting future harms likely to result from implementation of the Rule). Moreover, HHS can hardly pretend to conduct its rulemaking in a vacuum. *See Friends of Back Bay v. U.S. Army Corps. of Eng'rs*, 681 F.3d 581, 588 (4th Cir. 2012) ("A material misapprehension of the baseline conditions existing in advance of an agency action can lay the groundwork for an arbitrary and capricious decision."). HHS's unwillingness to consider the serious harms resulting from an expansion of refusal rights amidst currently widespread discrimination against vulnerable populations—an important aspect of the problem—further underscores that the Rule is arbitrary and capricious.

(4) The Department ignored evidence the Rule would undermine medical ethics

The Rule is also arbitrary and capricious because HHS failed to conduct a reasoned analysis of basic medical ethics in adopting the Rule. Courts have invalidated agency actions as arbitrary and capricious where, as here, the agency failed to take into consideration the "legal and ethical guidelines" at issue in the regulated industry. *See Am. Acad. of Pediatrics v. Heckler*, 561 F. Supp. 395, 399–400 (D.D.C. 1983) (holding HHS's action to be arbitrary and capricious where it failed to balance relevant factors "against the malpractice and disciplinary risks that may be imposed upon physicians and hospitals caught between the requirements of the regulation and established legal and ethical

guidelines"). Here, HHS received comments from numerous individuals and professional medical associations cautioning that the Rule's new statutory definitions—which now protect an employee who objects without notice and permits health care entities and providers to withhold basic information from patients—would contravene medical ethics and deprive patients of the ability to provide informed consent, one of the most critical and fundamental pillars of modern medical care. *See supra* at 12–22.

For example, the AMA, which for over a century has promulgated national medical ethics standards, explained in its comment to HHS that while it "supports conscience protections for physicians and other health professional personnel," under "the AMA *Code of Medical Ethics*, physicians' freedom to act according to conscience is not unlimited" because, inter alia, "[p]hysicians are expected to provide care in emergencies." Bays Decl., Ex. 12 at AR 139588. The AMA further explained that

> "[o]f key relevance to the Proposed Rule, the *Code* [*of Medical Ethics*] directs physicians to: . . . Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects . . . [R]efer a patient to another physician or institution to provide treatment the physician declines to offer. [And] [w]hen a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services."

Bays Decl., Ex. 12 at AR 139588. The AMA expressed its concern that "the Proposed Rule, by attempting to allow individuals and health care entities who receive federal funding to refuse to provide *any* part of a health service or program based on religious beliefs or moral convictions, will allow discrimination against patients, exacerbate health inequities, and undermine patients' access to care." Bays Decl., Ex. 12 at AR 139588.

Other commenters raised similar ethics issues to HHS, explaining that:

- The Rule "invites health care professionals to violate their legal and ethical duties of providing complete, accurate, and unbiased information necessary to obtain informed consent." Bays Decl., Ex. 19 at AR 138111 (comment by NFPRHA).
- The Rule threatens principles of informed consent by inviting "institutions and individual providers to withhold information about services to which they personally object, without regard for the patient's needs or wishes." Bays Decl., Ex. 20 at AR 134740–41 (comment by National Center for Lesbian Rights).
- "By allowing providers, including hospital and health care institutions, to refuse to provide patients with information, the [Rule] makes it impossible for patients to have full information regarding treatment options." Bays Decl., Ex. 21 at AR 148147 (comment by Physicians for Reproductive Health).

In response to these alarming comments, HHS blithely stated that it "disagrees that the rule would violate principles of informed consent" and then summarily declared that the Rule would not change the existing obligation "that doctors secure informed consent from patients before performing medical procedures." 84 Fed. Reg. at 23200; *see also id.* at 23189. But HHS utterly failed to meaningfully address or respond to the serious concerns raised by the AMA

and similar organizations. HHS's conclusory statements in the rulemaking process are insufficient to address such significant concerns. *See Encino Motorcars, LLC*, 136 S. Ct. at 2127 (explaining that where there are "serious reliance interests at stake," an agency's mere "conclusory statements do not suffice to explain its decision").

Even more callous was HHS's assertion that patients may mitigate the harm from a provider's withholding of information by conducting their own Google searches. 84 Fed. Reg. 23253, n.354. The suggestion would be laughable if it were not so sadly reflective of HHS's dismissive attitude toward patient harms. *See* Bays Decl., Ex. 14 at AR 147983 (comment by American College if Emergency Physicians) (warning that patients "will have no way of knowing which services, information, or referrals they may have been denied, or potentially whether they were even denied medically appropriate and necessary services to begin with"). HHS's failure to meaningfully consider and provide a "reasoned analysis" of the Rule's impact on medical ethics is yet another reason the Rule is arbitrary and capricious. *State Farm*, 463 U.S. at 42–43.

(5) HHS failed to address evidence discussing the significant harm associated with its abandonment of the Title VII framework

The Rule is also arbitrary and capricious because HHS failed to address evidence of significant harm resulting from its wholesale repudiation of Title VII's regulatory framework, which currently governs the handling of religious

objections in the workplace. Although Title VII carefully balances the interests of employers, employees, and patients, HHS has arbitrarily and without justification abandoned it for an unbalanced system where employers have no meaningful ability to protect their patients by anticipating or responding to their employees' religious objections.

Under Title VII, employers generally must accommodate employees' and prospective employees' religious beliefs unless the employer is "unable to reasonably accommodate [the] religious observance or practice without undue hardship on the conduct of the employer's business." 42 U.S.C. § 2000e(j). Title VII thus considers and balances all interests at stake, including by *requiring* employers to offer reasonable accommodations. The Rule, however, dramatically departs from this well-established framework to instead elevate an employee's individual religious beliefs above all other interests—including those of employers, coworkers, and patients. *See supra* at 20–22.

In light of this repudiation of Title VII's framework, many commenters warned that the Rule will lead to harmful and absurd results, including that "individual[s] could be hired into and remain in" jobs they refuse to perform, without any guardrails in place to "enable employers to take advance steps to ensure patients get the care they need." Bays Decl., Ex. 6 at AR 139643 (comment by Kaiser Permanente).

Notwithstanding these grave concerns, HHS provided little explanation of its decision to abandon the Title VII framework, except to argue that Congress "did not [expressly] adopt an undue hardship exception" in the various conscience statutes the Rule purports to interpret. 84 Fed. Reg. at 23191. This superficial explanation falls far short of what is necessary to justify a complete overhaul of the Title VII standard that has effectively governed workplaces for decades. *See Can-Am Plumbing, Inc. v. Nat'l Labor Relations Bd.*, 321 F.3d 145, 154 (D.C. Cir. 2003) (invalidating agency decision; "[f]requently the entire scope of Congressional purpose calls for careful accommodation of one statutory scheme to another, and it is not too much to demand of an administrative body that it undertake this accommodation").

d. The agency's "cost/benefit analysis" is speculative

In addition to fabricating justifications for the Rule, HHS also conducted a fundamentally flawed "cost-benefit analysis." ECF No. 44 at 51. Specifically, HHS purports to have "identified four primary benefits of the Rule in its cost-benefit analysis." ECF No. 44 at 51. But these alleged benefits are entirely speculative and are otherwise contradicted by a voluminous administrative record with scores of comments cataloguing the significant harms to be caused by the Rule.

First, HHS asserts that the Rule will "increase[e] the number of health care providers." ECF No. 44 at 51. But a review of the Rule reveals that this

determination was based on the unreliable 2009 and 2011 Kellyanne Conway surveys discussed above. *See supra* at 36–37; *see, e.g.*, 84 Fed. Reg. at 23246–47 and nn. 309, 316–18, 322; *id.* at 23247. A conclusion that the Rule will "at least not decrease" access to providers based upon an unreliable survey is entirely speculative and is entitled to no deference.

HHS's second claimed benefit—that the Rule will "improve[e] the doctor-patient relationship"—is equally specious. ECF No. 44 at 51. In support of this "benefit" the Rule cites a medical journal article for the proposition that "[i]t is important for patients seeking care to feel assured that their religious beliefs and their moral convictions will be honored" as "[t]his will ensure that they are being treated fairly." 84 Fed. Reg. at 23249 and nn.333, 334. But in its assessment of patient benefits, HHS completely ignores the extensive body of comments warning that the Rule would have a negative and discriminatory impact on many vulnerable populations, including women and those in the LGBT community. *See supra* at 46–48 (discussing the Rule's impact on vulnerable populations and providing representative comments in the administrative record on this issue).

Next, HHS contends that the Rule is beneficial because it "eliminate[es] the harm from requiring health care entities to violate their consciences" and will "reduce unlawful discrimination in the health care industry and promot[e] personal freedom." ECF No. 44 at 51. But these alleged benefits are based on a flawed factual premise. As discussed above, HHS's contention that there had

been a "significant increase" in the number of discriminatory complaints alleging violations of conscience rights was proved to be factually incorrect, *see supra* at 31–34; instead, the administrative record contains only a miniscule number of complaints on the issue that the Rule purports to address. Accordingly, there is no evidentiary basis to support the "benefit" of a reduction in conscious-based discrimination or the elimination of violations of a providers' conscience.

In sum, the Rule's purported benefits are not supported by competent evidence and, instead, are belied by the many comments from health care entities, national medical organizations, and civil rights group, warning of the dire impacts that this Rule will have on patient care. Because courts "do not defer to [an] agency's conclusory or unsupported suppositions," *McDonnell Douglas Corp. v. U.S. Dep't of the Air Force*, 375 F.3d 1182, 1187 (D.C. Cir. 2004), the Rule's baseless "benefits" analysis deserves no weight.

C. The Rule Is Unconstitutional

1. The Rule violates the constitutional separation of powers

Because the Constitution vests the spending power in Congress, the Executive Branch "does not have unilateral authority to refuse to spend . . . funds" already appropriated by Congress "for a particular project or program." *In re Aiken County*, 725 F.3d 255, 261 n.1 (D.C. Cir. 2013). The discretion the Executive Branch has to decide how to spend appropriated funds is cabined by the scope of Congress's delegation. *City of Arlington*, 569 U.S. at 296.

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In the refusal statutes, Congress clearly attached specific conditions to the acceptance of specific sources of funds, and not others, and has tailored those conditions to specific procedures and health care providers or entities. *See supra* at 15–26.

By contrast, the Rule redefines and impermissibly broadens key statutory terms, grants HHS broad investigative and compliance authority, and gives HHS the unilateral authority to terminate billions of dollars in congressionally appropriated federal funds. *Id*.

Thus the Rule goes far beyond merely "complying" with congressional dictates. *See* ECF No. 44 at 55. HHS has no authority to rewrite the statutes Congress enacted in this way. *City & County of San Francisco v. Sessions*, 372 F. Supp. 3d 928, 941 (N.D. Cal. 2019) (quoting *Immigration & Naturalization Serv. v. Chadha*, 462 U.S. 919, 959 (1983)). Nor does HHS have the authority to refuse to spend funds Congress appropriated for a particular program. *In re Aiken County*, 725 F.3d at 261 n.1 (citing *Train v. City of New York*, 420 U.S. 35, 42–45 (1975)).

2. The Rule violates the Spending Clause

The Rule also is unconstitutional under the Spending Clause. Article I, section 8, clause 1 of the United States Constitution states that "Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States."

Under the Spending Clause, an agency must not impose conditions on federal funds that are so coercive that they compel (rather than encourage) recipients to comply. *Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 567 U.S. 519, 575–78 (2012); *South Dakota v. Dole*, 483 U.S. 203, 206–08 (1987). Here the Rule is unconstitutionally coercive.

Under existing precedent, the Rule violates the Spending Clause by threatening to "penalize [recipients] that choose not to participate in [a] new program by taking away their existing [] funding." *NFIB*, 567 U.S. at 585, and by permitting the termination of the State's funding based on the conduct of third-party sub-grantees. *See Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 287–88 (1998) (notice required).

The Rule's threat to strip all federal funding if OCR deems the Rule violated is an unconstitutionally coercive "gun to the head." *NFIB*, 567 U.S. at 581; ECF No. 8 at 40–41 (detailing Washington's annual receipt of over $10.5 billion in federal funding from HHS, $1.1 billion from DOE, and $225 million from DOL); *see also* ECF No. 9 ¶ 5; ECF No. 19 ¶ 6; Harris Decl. (ECF No. 12) ¶ 24; Lindeblad Decl. (ECF No. 15) ¶ 2; ECF No. 16 ¶ 11.

The loss of funding leaves the State "with no real option but to acquiesce." *NFIB*, 567 U.S. at 581–82. This constitutes "economic dragooning" rather than "relatively mild encouragement" to comply. *See id.* at 581–82.

Further *NFIB* proscribes withdrawing existing funds provided to States as

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a penalty for not complying with new conditions. *Id.* at 585. Yet that is what the Rule does. *See supra* at 13–24 (detailing new conditions). The Rule is unconstitutionally coercive.

HHS claims that *NFIB* is distinguishable because HHS "will always begin trying to resolve a potential violation through informal means." ECF No. 44 at 57. But this blithe assurance does not change the choice the Rule imposes on States: comply with the Rule or give up all HHS funding. And the claim that "informal means" will be pursued first brings little comfort when HHS is authorized to terminate federal funding during the pendency of good faith compliance efforts and before a finding of noncompliance, 45 C.F.R. §§ 88.7(i)(2), 88.7(j)).

3. The Rule violates the Establishment Clause

The Establishment Clause bars official conduct that favors one faith over others, has the primary purpose or primary effect of advancing or endorsing religion, or coerces religious belief or practice. *See, e.g.*, *McCreary County v. ACLU of Ky.*, 545 U.S. 844, 860 (2005). The "touchstone" for analysis of an Establishment law claim is the principle that the "First Amendment mandates governmental neutrality between religion and religion, and between religion and nonreligion." *McCreary County*, 545 U.S. at 844 (quotation omitted).

a. The Rule provides employees with an unqualified right to refuse to work for religious reasons

The Rule violates the Establishment Clause because it allows individual employees to dictate whether and how patients receive health care based on their own personal views and requires health care employers to provide an absolute accommodation. The "Constitution guarantees that government may not coerce anyone to support or participate in religion or its exercise." *Lee v. Weisman*, 505 U.S. 577, 587 (1992). Concomitant to this premise is that a law that provides an absolute and unqualified right to refuse to work for religious reasons violates the Establishment Clause. *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 711 (1985).

In *Thornton*, the Supreme Court struck down a Connecticut statute which gave employees an "absolute and unqualified" right to refuse to work on whatever day they designated as their Sabbath. *Id*. at 708–09. The Court held the law in violation of the Establishment clause because it "imposed on employers and employees an absolute duty to conform their business practices to the particular religious practices of the employee" and thus commanded that "religious concerns automatically control over all secular interests at the workplace." *Id*. at 709. Additionally, the law took "no account of the convenience or interests of the employer or those of other employees" and required that the "employer and others must adjust their affairs to the command of the State

whenever the statute is invoked by an employee." *Id*. This is precisely what the Rule does in violation of the Establishment Clause.

The Rule requires Plaintiffs to absolutely accommodate any employee who refuses to "assist in the performance" of any medical procedure. *See supra* at 22–24. Specifically, the Rule requires health care employers to allow employees to refuse to provide information or services even in emergencies or when the services are part of the primary duties of the job. 84 Fed. Reg. at 23190–91, 23192. Any other accommodation may be refused regardless of how reasonable the accommodation is or whether there is any undue hardship or other burden on employers. *Id.* at 23191. Nor may an employer attempt to meet business or patient needs by using alternate staff if doing so would require the conscience objector to take "any" additional action (such as informing the other non-objecting staff), or if it would functionally exclude the objector from any "fields of practice." *Id.* at 23191. Worse, a health care employer may not ask prospective employees whether they are willing to perform essential job functions. *Id.* at 23263.

Thus, the Rule imposes on health care employers exactly the kind of absolute duty to conform business practices to the religious beliefs of employees that the Supreme Court prohibited in *Thornton*: a health care employer is automatically to place religious concerns over the secular needs and interest of the workplace with no consideration of the interests or convenience of the employers, fellow employees, or patients. *Thornton*, 472 U.S. at 709. This

"unyielding weighting in favor of [religious beliefs] over all other interests contravenes a fundamental principal": that "[t]he First Amendment . . . gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities." *Id*. (citation omitted).

The duty imposed by the Rule is no less absolute because a health care entity could simply refuse to accept federal funding. ECF No. 44 at 63. Under this reasoning the employer in *Thornton* could have simply chosen not to operate his business on an employee's Sabbath day. But refusing over $10.5 billion in federal funding from HHS, over $1.1 billion from the Department of Education, and over $225 million from the Department of Labor would lead to immediate and harsh budget cuts with devastating effects on the State and Washingtonians due to the loss of services. Shaub Decl. (ECF No. 18) ¶ 6.

Further, it is well-settled that "even though a person has no 'right' to a valuable governmental benefit and even though the government may deny him the benefit for any number of reasons . . . [i]t may not deny a benefit to a person on a basis that infringes his constitutionally protected interests." *Perry v. Sindermann*, 408 U.S. 593, 597 (1972). Otherwise the government could "produce a result which (it) could not command directly." *Id*. (citation and internal quotations omitted). Defendants are not entitled to deny federal funding by way of conditions that require religion to be preferred over non-religion.

b. The Rule impermissibly burdens patients and third parties with employees' religious beliefs

The Establishment Clause prohibits religious exemptions or accommodations by government that would have a "detrimental effect on any third party," *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014), because these accommodations impermissibly prefer the religion of those who are benefited over the beliefs and interests of those who are not. *See, e.g., Texas Monthly, Inc. v. Bullock*, 489 U.S. 1, 15, 18 (1989) (plurality opinion); *Thornton*, 472 U.S. 703. In evaluating this well settled authority, courts must "account [for] the burdens a requested accommodation may impose on nonbeneficiaries" and ensure that the accommodation does not "override other significant interests." *Cutter v. Wilkinson*, 544 U.S. 709, 720, 722 (2005).

The Rule provides an absolute religious exemption or accommodation that will harm Washington's health care institutions and the Washingtonians that rely on the services provided by those institutions. Washington has laws, consistent with existing federal law, that ensure that patients can receive their full options of health care while respecting employees' religious beliefs. *See* ECF No. 1 ¶¶ 37–74. The Rule undermines essential patient protections by inviting employees, contractors, and volunteers of health care institutions to deny care to patients based on religious, moral, or other objections to the treatment or to the characteristics or circumstances of the patient, without regard to the harms they will impose on patients and providers.

By hamstringing Washington and its health care institutions' ability to make appropriate accommodations, refusals will result in delays or denials of care. The Rule's elevation of certain religious rights over all else places Washington and its citizens in an impossible bind—whether Washington complies with the Rule or chooses to forgo billions of dollars in federal funding, the public health will be unreasonably burdened and suffer significant harm.

Defendants erroneously rely on *Corp. of Presiding Bishop of Church of Jesus Christ of Latter-day Saints v. Amos (Amos)*, 483 U.S. 327, 335 (1987) to argue that the Establishment clause does not bar accommodations that could adversely affect others. ECF No. 44 at 62–63. But in that case the Court recognized that "[a] law is not unconstitutional simply because it allows churches to advance religion, which is their very purpose" rather a law will have "forbidden" effects if "the government itself has advanced religion through its own activities and influence." *Amos*, 483 U.S. at 337.

Here, the Rule's plain language and record show that it squarely uses government influence to advance religion and requires secular businesses to "conform their business practices to the particular religious practices of the[ir] employees." *Thornton*, 472 U.S. at 709. The Rule states that it "furthers a presidential priority" (84 Fed. Reg. at 23227) expressed in Executive Order 13798 which provides that "[i]t shall be the policy of the executive branch to vigorously enforce Federal law's robust protections for religious freedom." 82

Fed. Reg. 21675, 21675 (May 4, 2017). The Rule also cites lawsuits against religiously-affiliated hospitals as a reason for the Rule, 84 Fed. Reg. at 23176 & n.27, prioritizes the interests of faith-based health care providers, *id*. at 23246–47 & n.322, and relies on a 2009 survey of "members of faith-based medical associations." *Id*. at 23175, 23246, 23247, 23253.

Further, the Notice of Proposed Rulemaking makes clear that the Rule advances religious interests when it proposed a rule "in keeping with the Attorney General's religious liberty guidance," which "protects not just the right to believe or the right to worship; it protects the right to perform or abstain from performing certain physical acts in accordance with one's beliefs." 83 Fed. Reg. 3880, 3881 (Jan. 26, 2018) (quoting Memorandum from the Attorney General, Federal Law Protections for Religious Liberty at 2 (Oct. 6, 2017)).

Finally, *Amos* and subsequent cases recognize that burdens on nonbeneficiaries imposed by accommodations for religious belief can violate the Establishment Clause and should be taken into account. *Amos*, 483 U.S. at 334–35; *Cutter*, 554 U.S. at 720; *Bd. of Educ. of Kiryas Joel Vill. Sch. Dist. v. Grumet*, 512 U.S. 687, 706 (1994).

c. The Rule impermissibly coerces patients and providers to adhere to the government favored religious practices

The "Constitution guarantees that government may not coerce anyone to support or participate in religion or its exercise." *Lee*, 505 U.S. at 587. But the Rule allows individual employees to dictate whether and how patients receive

health care based on their own personal views. It further requires health care employers to provide an absolute accommodation without exception. The Rule thus coerces health care employers to support the exercise of the religion of those employees to the detriment of patient health. This is true even when those beliefs are expressly contrary to the mission of the agencies and institutions providing the care or to the patients' own beliefs. *See, e.g.*, Saxe Decl. (ECF No. 17) ¶¶ 13–15; ECF No. 15 ¶¶ 3, 6, 13; ECF No. 12 ¶¶ 3, 52–54. For these reasons, the Rule violates the Establishment Clause.

D. The Court Should Vacate the Rule

The normal rule under the APA is that when a rule is unlawful it is vacated or "set aside," not somehow limited in application to persons other than the plaintiffs. 5 U.S.C. § 706(2); *Regents of the Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, 908 F.3d 476, 511 (9th Cir. 2018) ("[W]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed."); *All. for the Wild Rockies v. United States*, 907 F.3d 1105, 1121–22 (9th Cir. 2018) ("[O]rdinarily when a regulation is not promulgated in compliance with the APA, the regulation is invalid."). Vacatur by its nature has nationwide effect.

The cases HHS cites for plaintiff-specific relief are inapposite. Three cases involved different remedial authority—equitable relief for alleged constitutional

violations, not a statutory remedy under the APA. *Gill v. Whitford*, 138 S. Ct. 1916, 1926–29 (2018); *Madsen v. Women's Health Ctr.*, 512 U.S. 753, 757 (1994); *City & County of San Francisco v. Trump*, 897 F.3d 1225, 1244–45 (9th Cir. 2018). Two address preliminary, not permanent, relief. *California v. Azar*, 911 F.3d 558, 582 (9th Cir. 2018); *Trump v. Hawaii*, 138 S. Ct. 2392, 2405 (2018). *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 307–11 (1982), did not involve a challenge to an agency rule, so vacatur was not at issue. HHS's quotation from *Abbott Labs v. Gardner*, 387 U.S. at 155, addressed courts' exercise of equitable authority to prevent litigation used to harass the government or delay enforcement of rules. HHS cites no case ordering a more limited remedy than vacatur on a final judgment in an APA case.

Further, it is untenable for HHS to suggest that the Court sever the remaining portions of the Rule from the unlawful sections, because the unlawful sections provide the substantive requirements of the Rule. "Whether the offending portion of a regulation is severable depends upon the intent of the agency *and* upon whether the remainder of the regulation could function sensibly without the stricken provision." *MD/DC/DE Broadcasters Ass'n v. FCC*, 236 F.3d 13, 22 (D.C. Cir. 2001). HHS has not attempted to explain how the Rule could operate without the severed substantive requirements of the Rule. The challenged definitions provide the very law HHS would apply in any enforcement action, so it is impossible to sever the remainder of the Rule from them. If the

Court were to vacate the definition of "discrimination," there would be no prohibitions for HHS to enforce. *See* 45 C.F.R. §§ 88.3(a)(2)(iv), (v), (vii); 88.3(b)(2)(i); 88.3(c)(2); 88.3(e)(2). Likewise, if the Court vacated the definition of "assist in the performance," the scope of the Rule would be indeterminate; HHS cannot practically enforce a rule without knowing its scope. *See* 45 C.F.R. §§ 88.3(a)(2)(i), (iii), (vi). Similarly, the definitions of "referral" and "health care entity" are fundamental to the reach of HHS's claimed enforcement power. If these provisions were vacated, there would be no substantive content to HHS's requirements of assurance and certification, notice, and compliance in 45 C.F.R. §§ 88.4, 88.5, and 88.6.[11]

III. CONCLUSION

For the reasons set forth above, the State of Washington respectfully requests that the Court grant the State's motion for summary judgment, deny HHS's cross-motion, and vacate and set aside the Rule.

[11] The Court should refuse HHS's request for an advisory opinion on the propriety or legality of unidentified "ongoing investigations." ECF No. 44 at 66.

RESPECTFULLY SUBMITTED this 20th day of September, 2019.

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DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 20th day of September, 2019, at Seattle, Washington.

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